FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011643

Facility Name: SUNSET HOME

Address: 418 WASHINGTON STREET (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: 217-223-2636 **Fax #** 217-223-9867

IDPA ID Number: 3706615224-001

Date of Initial License for Current Owners: NOT AVAILABLE

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DAVID WILSON **Telephone Number:** 217-223-2636 EXT 311

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10-1-2004 to 9-30-2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 12/1/2005 (Date)
(Type or Print Name) JUDY KIRLIN
(Title) CEO/ADMINISTRATOR

Paid Preparer

(Signed) (Date)
(Print Name and Title) TIMOTHY WIEWEL, PROPRIETOR
(Firm Name & Address) TIMOTHY J WIEWEL CPA, PO BOX 1028 QUINCY IL 62306
(Telephone) 217-223-2245 Fax # 217-223-7580

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	19	Skilled (SNF)	19	6,935	1
2		Skilled Pediatric (SNF/PED)			2
3	152	Intermediate (ICF)	152	55,480	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31	11,315	5
6		ICF/DD 16 or Less			6
7	202	TOTALS	202	73,730	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	36	0	4,779	4,815	8
9	SNF/PED					9
10	ICF	22,881	27,999		50,880	10
11	ICF/DD					11
12	SC	894	4,561		5,455	12
13	DD 16 OR LESS					13
14	TOTALS	23,811	32,560	4,779	61,150	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.94%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
INDIVDUAL LIVING UNITS, SENIOR APARTMENTS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started / /

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 4,779

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	587,455	37,982	9,552	634,989		634,989		634,989			1
2	Food Purchase		228,226		228,226		228,226		228,226			2
3	Housekeeping	250,898	46,971		297,869		297,869		297,869			3
4	Laundry	47,109	1,410	143,713	192,232		192,232		192,232			4
5	Heat and Other Utilities			346,830	346,830		346,830		346,830			5
6	Maintenance	190,807	48,418	72,030	311,255	(3,359)	307,896	(21,009)	286,887			6
7	Other (specify):*											7
8	TOTAL General Services	1,076,269	363,007	572,125	2,011,401	(3,359)	2,008,042	(21,009)	1,987,033			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,802,109	188,277	36,657	4,027,043		4,027,043		4,027,043			10
10a	Therapy	13,620	2,790	310,156	326,566		326,566		326,566			10a
11	Activities	143,358	6,563	9,513	159,434		159,434		159,434			11
12	Social Services	93,213	2,499		95,712		95,712		95,712			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,052,300	200,129	356,326	4,608,755		4,608,755		4,608,755			16
	C. General Administration											
17	Administrative	84,413			84,413		84,413		84,413			17
18	Directors Fees											18
19	Professional Services			71,374	71,374		71,374	(29,725)	41,649			19
20	Dues, Fees, Subscriptions & Promotions			29,710	29,710		29,710		29,710			20
21	Clerical & General Office Expenses	283,107	10,780	97,092	390,979		390,979	(475)	390,504			21
22	Employee Benefits & Payroll Taxes			1,033,232	1,033,232	(4,546)	1,028,686		1,028,686			22
23	Inservice Training & Education			2,653	2,653		2,653		2,653			23
24	Travel and Seminar			16,651	16,651		16,651	(2,597)	14,054			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			161,298	161,298		161,298		161,298			26
27	Other (specify):* BAD DEBT			147	147		147	(147)				27
28	TOTAL General Administration	367,520	10,780	1,412,157	1,790,457	(4,546)	1,785,911	(32,944)	1,752,967			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,496,089	573,916	2,340,608	8,410,613	(7,905)	8,402,708	(53,953)	8,348,755			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SUNSET HOME #0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			483,369	483,369	(123,653)	359,716		359,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			764	764		764	(764)				32
33	Real Estate Taxes					3,359	3,359	(3,315)	44			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			484,133	484,133	(120,294)	363,839	(4,079)	359,760			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			93,399	93,399		93,399		93,399			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			93,623	93,623		93,623		93,623			42
43	Other (specify):*			568,898	568,898	128,199	697,097	(697,097)				43
44	**TOTAL Special Cost Centers**			755,920	755,920	128,199	884,119	(697,097)	187,022			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,496,089	573,916	3,580,661	9,650,666		9,650,666	(755,129)	8,895,537			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,384)	6		5
6	Rented Facility Space	(8,625)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(764)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(475)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(29,725)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(147)	27		24
25	Fund Raising, Advertising and Promotional	(55,706)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE 5-A	(647,303)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (755,129)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (755,129)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SUNSET HOME

ID# 0011643

Report Period Beginning: 10-1-2004

Ending: 9-30-2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	OUT OF STATE TRANSPORTATION SEMINAR	$ (2,099)	24	1
2	REAL ESTATE TAXES	(3,315)	33	2
3	VILLA APRTMENTS	(89,225)	43	3
4	SUNSET APARTMENTS	(552,166)	43	4
5	FY 2006 SEMINAR PAID 2005	(498)	24	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(647,303)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10-1-2004 **Ending:** 9-30-2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(21,009)	0	0	0	0	0	0	0	0	0	0	(21,009)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(21,009)	0	0	0	0	0	0	0	0	0	0	(21,009)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(29,725)	0	0	0	0	0	0	0	0	0	0	(29,725)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(475)	0	0	0	0	0	0	0	0	0	0	(475)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,597)	0	0	0	0	0	0	0	0	0	0	(2,597)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(147)	0	0	0	0	0	0	0	0	0	0	(147)	27
28	**TOTAL General Administration**	(32,944)	0	0	0	0	0	0	0	0	0	0	(32,944)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(53,953)	0	0	0	0	0	0	0	0	0	0	(53,953)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10-1-2004 **Ending:** 9-30-2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(764)	0	0	0	0	0	0	0	0	0	0	(764)	32
33	Real Estate Taxes	(3,315)	0	0	0	0	0	0	0	0	0	0	(3,315)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,079)	0	0	0	0	0	0	0	0	0	0	(4,079)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(697,097)	0	0	0	0	0	0	0	0	0	0	(697,097)	43
44	**TOTAL Special Cost Centers**	(697,097)	0	0	0	0	0	0	0	0	0	0	(697,097)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(755,129)	0	0	0	0	0	0	0	0	0	0	(755,129)	45

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MERCANTILE		X	CONSTRUCTION LOAN -			$	$ 1,077,248	12/19/2028	0.0450	$	1
2				INTEREST CAPITALIZED								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,077,248			$	9
	B. Non-Facility Related*											
10	GIFT ANNUITIES		X	NONE							764	10
11	MERCANTILE		X	PURCHASE APART LOC				128,306	12/21/2007	0.0525	17,755	11
12	MERCANTILE		X	APARTMENTS PERM LOAN			2,850,000	2,850,000	12/19/2028	0.0450	130,103	12
13												13
14	TOTAL Non-Facility Related						$ 2,850,000	$ 2,978,306			$ 148,622	14
15	TOTALS (line 9+line14)						$ 2,850,000	$ 4,055,554			$ 148,622	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	344	2
3. Under or (over) accrual (line 2 minus line 1).	$	344	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	344	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001	552	9
2002	567	10
2003	574	11
2004	344	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SUNSET HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-2-0917-000-00	VACANT LOT	$ 87.70	$ 87.70
2.	23-2-0973-000-00	VACANT LOT	$ 41.32	$ 41.32
3.	23-2-0926-000-00	VACANT LOT	$ 173.96	$ 173.96
4.	23-2-0972-000-00	VACANT LOT	$ 41.32	$ 41.32
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 344.30	$ 344.30

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 144,818 B. General Construction Type: Exterior BRICK Frame STEEL-FIREPROOF Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

VILLA APARTMENTS 16 - 2 BEDROOM UNITS 16,000 SQ FT

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	199,487		$ 102,419	1
2	PARKING LOT ADDITIONAL	15,000	1996-97	86,288	2
3	TOTALS	214,487		$ 188,707	3

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	34		1958	1958	$ 354,000	$ 7,080	50	$ 7,080	$	$ 336,300	4
5	71		1971	1971	1,218,562	24,371	50	24,371		828,595	5
6	49		1972	1972	472,577	9,452	50	9,452		318,995	6
7	5		1987	1987	68,497	3,425	20	3,425		61,934	7
8	43		2001	2001	2,500,281	83,343	30	83,343		333,371	8
	Improvement Type**										
9	BUILDINGS & IMPROVEMENTS			1958	12,000		10			12,000	9
10	BUILDINGS & IMPROVEMENTS			1972	51,124	1,023	50	1,023		33,749	10
11	BUILDINGS & IMPROVEMENTS			1977	14,179		20			14,179	11
12	BUILDINGS & IMPROVEMENTS			1978	442,103	8,842	50	8,842		243,271	12
13	BUILDINGS & IMPROVEMENTS			1979	13,639	273	50	273		7,231	13
14	BUILDINGS & IMPROVEMENTS			1980	771		20			771	14
15	BUILDINGS & IMPROVEMENTS			1981	3,742		10			3,742	15
16	BUILDINGS & IMPROVEMENTS			1982	13,900		10			13,900	16
17	BUILDINGS & IMPROVEMENTS			1983	14,951		20			14,951	17
18	BUILDINGS & IMPROVEMENTS			1985	272,013	6,800	40	6,800		138,150	18
19	BUILDINGS & IMPROVEMENTS			1987	321,886	14,347	10-20	14,347		301,535	19
20	BUILDINGS & IMPROVEMENTS			1988	36,315	239	10-20	239		35,740	20
21	BUILDINGS & IMPROVEMENTS			1989	99,114	4,173	10-20	4,173		86,918	21
22	BUILDINGS & IMPROVEMENTS			1990	36,949	1,847	20	1,847		27,938	22
23	BUILDINGS & IMPROVEMENTS			1992	11,222	156	10-20	156		10,177	23
24	BUILDINGS & IMPROVEMENTS			1993	33,274	1,241	5-20	1,241		23,511	24
25	BUILDINGS & IMPROVEMENTS			1994	9,466	382	5-20	382		6,220	25
26	BUILDINGS & IMPROVEMENTS			1995	99,649	6,250	5-15	6,250		76,159	26
27	BUILDINGS & IMPROVEMENTS			1996	33,788	1,256	5-20	1,256		20,161	27
28	BUILDINGS & IMPROVEMENTS			1997	401,000	19,468	5-20	19,468		182,108	28
29	BUILDINGS & IMPROVEMENTS			1998	107,004	5,298	5-20	5,298		42,895	29
30	BUILDINGS & IMPROVEMENTS			1999	3,684	368	10	368		2,395	30
31	BUILDINGS & IMPROVEMENTS			2000	35,444	1,772	20	1,772		8,501	31
32	BUILDINGS & IMPROVEMENTS			2001	24,121	2,230	10-20	2,230		8,826	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	COURT YARDEN GARDEN DOOR & STRIKE	2002	$ 3,422	$ 342	10	$ 342	$	$ 1,198	37
38	HOLLOW METAL DOORS	2002	4,573	457	10	457		1,601	38
39	REROOF CHAPEL	2002	3,600	360	10	360		1,260	39
40	REROOF KITCHED AND CAFETERIA	2002	18,300	1,830	10	1,830		6,405	40
41	KITCHEN FREEZER DEFROSTER TIMER	2002	1,115	112	10	112		390	41
42	PLANK FLOOR 2 FLOOR IN FRONT OF VILLA VIEW	2002	4,487	449	10	449		1,570	42
43	REMODEL B SHOP	2002	4,722	472	10	472		1,653	43
44	CONVERT 366 & 368 TO 2 PRIVATE ROOMS	2002	8,771	439	20	439		1,096	44
45	3 DOORS- REHAB OFFICE CAE PLAN ROOM	2004	1,628	163	10	163		244	45
46	PLUMBING FIXTURES ROOM 364	2004	8,800	440	20	440		660	46
47	CARPET DINING ROOM	2004	1,464	146	5	146		293	47
48	2 12*10 OVERHEAD DOORS	2004	4,150	415	10	415		415	48
49									49
50	FIXED EQUIPMENT	1971	814,827		25			814,827	50
51	FIXED EQUIPMENT	1972	253,064		25			253,063	51
52	FIXED EQUIPMENT	1978	280,726		25			280,726	52
53	FIXED EQUIPMENT	1979	13,938		10			13,938	53
54	FIXED EQUIPMENT	1984	23,531		10			23,531	54
55	FIXED EQUIPMENT	1985	117,689	3,511	5-20	3,511		117,687	55
56	FIXED EQUIPMENT	1986	13,909		10-15			13,908	56
57	FIXED EQUIPMENT	1987	12,320	320	10-20	320		11,706	57
58	FIXED EQUIPMENT	1988	8,162	241	10-20	241		7,603	58
59	FIXED EQUIPMENT	1989	4,670		15			4,670	59
60	FIXED EQUIPMENT	1993	259,307	11,891	10-20	11,891		168,144	60
61	FIXED EQUIPMENT	1995	188,017	9,621	10-20	9,621		98,537	61
62	FIXED EQUIPMENT	1996	10,809	1,037	10-15	1,037		9,199	62
63	FIXED EQUIPMENT	1997	35,461	1,812	15-20	1,812		15,091	63
64	FIXED EQUIPMENT	1998	180,143	9,222	15-20	9,222		69,085	64
65	FIXED EQUIPMENT	1999	8,744	526	15-20	526		3,064	65
66	FIXED EQUIPMENT	2000	272,461	14,155	10-20	14,155		73,718	66
67	FIXED EQUIPMENT	2001	40,619	2,424	10-20	2,424		9,426	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,308,684	$ 264,021		$ 264,021	$	$ 5,198,931	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,308,684	$ 264,021		$ 264,021	$	$ 5,198,931	1
2	5TON ROOFTOP KITCHEN AIR CONDITIONER	2002	6,100	610	10	610		2,135	2
3	CHILLER SE WING	2002	26,230	1,749	15	1,749		6,120	3
4	90 SMOKE SMART DETECTORS	2002	1,756	117	15	117		410	4
5	SPRINKLER SYSTEM REPAIR	2002	2,980	119	25	119		417	5
6	REPLACED AIR SEPARRTOR CENTRAL MECH	2002	2,810	187	15	187		656	6
7	REPLACED CENTER BOILER SECTION	2002	5,328	355	15	355		1,243	7
8	11 DOORS SPECIAL LOCKING UNITS MAGNETIC	2002	24,522	1,635	15	1,635		4,087	8
9	NEW DOOR OPERTORHW WEST ELEVATOR	2002	3,600	180	20	180		450	9
10	2 CENTER SECTION BOILERS#3	2002	4,950	330	15	330		825	10
11	CONVECTION OVEN	2002	3,328	222	15	222		555	11
12	INTERMEDIATE SECTION BOILER	2003	5,300	353	15	353		883	12
13	HW ELEVATOR WEST	2003	44,290	2,215	20	2,215		5,536	13
14	4TH FLOOR SMOKE DETECTORS	2003	3,231	215	15	215		539	14
15	5 PANIC HARDWARE W/SWITCHES	2003	3,750	250	15	250		625	15
16	CABLE FOR ELEVATOR	2003	4,226	211	20	211		528	16
17	BOILER PLANT NEW PIPING AND CONTROLSS 90%	2003	16,754	1,117	15	1,117		2,234	17
18	BOILER REPAIR #2	2003	4,317	288	15	288		720	18
19	PROJECT 2 3 4 FLOORS SMOKE DETECTORS	2003	6,707	447	15	447		671	19
20	REPLACE NURSE CALL STATION ON 3 WEST	2003	1,447	72	20	72		109	20
21	RELOCATE SMOKE DETECTORS	2003	6,179	412	15	412		618	21
22	ADD 3 DOOR ALARMS	2003	4,117	274	15	274		412	22
23	INSTALL 71 FIRE DAMPERS	2003	4,757	317	15	317		476	23
24	INSTALL 18 CEILING RADIATION FIRE DAMPERS	2004	3,840	256	15	256		384	24
25	REPLACE COPPER LINES & VALVES STORAGE TANK	2004	6,597	264	25	264		396	25
26	REPLACE CRACKED SECTION BOILER #3	2004	4,317	288	15	288		432	26
27	NEW HANDRAIL OUTSIDE RAMP TO DINING HALL	2004	14,780	985	15	985		1,478	27
28	BOILER PLANT PROBLEMS	2004	5,000	333	15	333		500	28
29	HOT WATER RHEEM GBCP 12 BOILER	2004	6,540	436	15	436		654	29
30	INSTALL 2 SPRAGUE 1 1/4" GAS CONTROL REGULATORS	2004	2,043	136	15	136		204	30
31	PROJECT 2 3 4 FLOORS SMOKE DETECTORS	2004	1,946	130	15	130		195	31
32	REPLACE CYLINDER ON KITCHEN ELEVATOR	2004	18,600	930	20	930		1,395	32
33	REPLACE EXV VALVE ON EAST CHILLER	2004	1,526	102	15	102		153	33
34	TOTAL (lines 1 thru 33)		$ 9,560,552	$ 279,556		$ 279,556	$	$ 5,234,971	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,560,552	$ 279,556		$ 279,556	$	$ 5,234,971	1
2	REPAIR BOILERS 1&2	2004	3,365	224	15	224		337	2
3	1 3POLE 600V 225A CIRCUIT BREAKER	2004	1,133	28	20	28		28	3
4	CHILLER REPLACEMENT	2004	72,429	2,414	15	2,414		2,414	4
5	NEW 4" RPZ VALVE IN SPRINKLER SYSTEM	2005	3,556	71	25	71		71	5
6	REPIR BOILER & NEW GASKETS & SECTIONS BOILER #2	2005	9,217	307	15	307		307	6
7	NEW DAMPER WEST PENTHOUSE	2005	4,556	152	15	152		152	7
8	NEW 480 WATT DISCONNECT	2005	6,268		20				8
9	BUSBOY DISPOSER	2005	1,708	57	15	57		57	9
10	WANDERGUARD SYSTEM AT HAVEN	2005	4,048	135	15	135		135	10
11	NEW CARD PHONE SYSTEM	2005	1,192	60	10	60		60	11
12									12
13	LAND IMPROVRMENTS	1975	2,807		25			2,807	13
14	LAND IMPROVRMENTS	1978	495		10			495	14
15	LAND IMPROVRMENTS	1979	6,425		10			6,425	15
16	LAND IMPROVRMENTS	1992	56,865		10			56,865	16
17	LAND IMPROVRMENTS	1995	18,601	1,550	12	1,550		16,146	17
18	LAND IMPROVRMENTS	1997	4,800	192	25	192		1,632	18
19	LAND IMPROVRMENTS	1999	44,219	3,685	12	3,685		23,953	19
20	LAND IMPROVRMENTS	2000	17,559	1,255	10-25	1,255		10,637	20
21	LAND IMPROVRMENTS	2001	1,952	195	10	195		878	21
22	CONCRETE WORK	2003	8,404	560	15	560		1,400	22
23	SIDEWALK	2004	3,450	230	15	230		345	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	ROUNDING		(7)					(1)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,833,594	$ 290,671		$ 290,671	$	$ 5,360,114	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 486,247	$ 49,619	$ 49,619	$		$ 244,898	71
72	Current Year Purchases	29,469	2,030	2,030		4-15	2,030	72
73	Fully Depreciated Assets	218,776					218,776	73
74								74
75	TOTALS	$ 734,492	$ 51,649	$ 51,649	$		$ 465,704	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINTENANCE	1997 3/4 TON GMC & PLOW	1997	$ 23,521	$	$	$	4-5	$ 23,521	76
77	RESIDENT TRANSPORT	2001 E-450 FORD BUS	2001	56,836	11,367	11,367		5	39,785	77
78	RESIDENT TRANSPORT	1994 FORD VAN	1995	36,216				4	36,216	78
79	RESIDENT TRANSPORT	2005 TRANSPORT BUS	2005	50,391	6,299	6,299		4	6,299	79
80	TOTALS			$ 166,964	$ 17,666	$ 17,666	$		$ 105,821	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,923,757	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 359,986	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 359,986	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,931,639	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	VILLA INDEP UNITS 1988-89-91	$ 1,710,465	$ 45,007	$ 710,859	86
87	SUNSET APARTMENTS	2,752,010	78,646	157,695	87
88					88
89					89
90					90
91	TOTALS	$ 4,462,475	$ 123,653	$ 868,554	91

G. Construction-in-Progress

	Description	Cost	
92	RENOVATION 1,2,4	$ 1,209,904	92
93			93
94			94
95		$ 1,209,904	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   COMMUNITY COLLEGE TRAINS AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

STATE OF ILLINOIS

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 120,652	$		$ 120,652	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			42,870			42,870	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			146,634			146,634	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				93,399		93,399	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 310,156	$ 93,399		$ 403,555	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10-1-2004 **Ending:** 9-30-2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9-30-2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 215,619	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	864,814		3
4	Supply Inventory (priced at COST)	52,524		4
5	Short-Term Investments	351,317		5
6	Prepaid Insurance	56,476		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,540,750	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	188,707		13
14	Buildings, at Historical Cost	9,833,594		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	901,456		16
17	Accumulated Depreciation (book methods)	(5,931,639)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,334,338		21
22	Other Long-Term Assets (spe CWIP	1,209,904		22
23	Other(specify): SEE ATTACHED	5,974,520		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 14,510,880	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,051,630	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 190,155	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	437,888		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,673		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SUNSET APARTMENTS	82,720		36
37	HEALTH CLAIM RESERVES	58,706		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 773,142	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,077,248		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	N/P SUNSET APARTMENTS	2,978,306		43
44	REF FEES & DEFERRED REVENUE	73,187		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,128,741	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,901,883	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,149,747	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,051,630	$	48

***(See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10-1-2004 **Ending:** 9-30-2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,980,230	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,980,230	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	169,517	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 169,517	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,149,747	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,540,384	1
2	Discounts and Allowances for all Levels	(1,410,920)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,129,464	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	240	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,625	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,865	23
	D. Non-Operating Revenue		
24	Contributions	623,086	24
25	Interest and Other Investment Income***	184,789	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 807,875	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE ATTACHED	815,526	28
28a	CHANGE IN VALUE SPLIT INTEREST AGREEMENT	58,453	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 873,979	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,820,183	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,011,401	31
32	Health Care	4,608,755	32
33	General Administration	1,790,457	33
	B. Capital Expense		
34	Ownership	484,133	34
	C. Ancillary Expense		
35	Special Cost Centers	93,399	35
36	Provider Participation Fee	93,623	36
	D. Other Expenses (specify):		
37	FUND DEVELOPMENT	51,160	37
38	SUNSET APARTMENTS	473,520	38
39	VILLAINDEP LIVING UNITS	44,218	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,650,666	40
41	**Income before Income Taxes (line 30 minus line 40)****	169,517	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 169,517	43

***** **This must agree with page 4, line 45, column 4.**

****** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

******* **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,941	2,074	$ 61,214	$ 29.51	1
2	Assistant Director of Nursing	2,086	1,870	49,421	26.43	2
3	Registered Nurses	26,245	24,832	492,744	19.84	3
4	Licensed Practical Nurses	84,602	92,842	1,358,857	14.64	4
5	CNAs & Orderlies	166,253	179,173	1,723,486	9.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,958	2,086	13,620	6.53	8
9	Activity Director	1,805	2,078	26,577	12.79	9
10	Activity Assistants	12,162	13,302	107,584	8.09	10
11	Social Service Workers	7,181	7,923	93,212	11.76	11
12	Dietician					12
13	Food Service Supervisor	1,838	2,086	36,792	17.64	13
14	Head Cook	1,754	2,086	30,178	14.47	14
15	Cook Helpers/Assistants	51,406	55,899	464,280	8.31	15
16	Dishwashers	5,610	6,224	56,057	9.01	16
17	Maintenance Workers	11,674	12,603	145,241	11.52	17
18	Housekeepers	26,998	28,904	229,352	7.93	18
19	Laundry	3,799	4,171	39,927	9.57	19
20	Administrator	1,820	2,086	84,413	40.47	20
21	Assistant Administrator					21
22	Other Administrative	5,449	6,182	114,793	18.57	22
23	Office Manager					23
24	Clerical	13,304	14,898	168,313	11.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,484	3,926	38,868	9.90	31
32	Other Health Care(specify)	7,962	8,491	77,518	9.13	32
33	Other(specify)	3,989	4,373	83,642	19.13	33
34	TOTAL (lines 1 - 33)	443,320	478,109	$ 5,496,089 *	$ 11.50	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,625	1-3	35
36	Medical Director		3,600	10-3	36
37	Medical Records Consultant		1,500	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,884	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,473	11-3	44
45	Social Service Consultant		2,473	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,555		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY KIRLIN	CEO/ADMIN	0	$ 84,413
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 84,413

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
SCHOLZ LOOS PALMER SIEBER	LEGAL	$ 15,601
LEGAL FEES PAID BY RESIDENT	LEGAL	(5,639)
TIMOTHY J WIEWEL CPA	AUDIT/ACCTG	22,750
FROST & RUTTENBERG	MEDICARE ACCTG	4,160
DR HENDRIX	HUMAN RESOURCES	4,777
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 41,649

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,481
Unemployment Compensation Insurance	14,455
FICA Taxes	407,157
Employee Health Insurance	366,526
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
DISABILITY INSURANCE	5,789
PENSION - 401K	113,139
EMPLOYEE AWARDS	23,819
PHYSICALS	3,505
LESS FUND DEVELOPMENT	(4,546)
VACATION PERSONAL TIME	(20,639)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,028,686

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,257
Health Care Worker Background Check	1,000
(Indicate # of checks performed)	
LIFE SERVICES NETWORK DUES	9,142
UNITED METHODIST DUES- EAGLE	7,747
OTHER DUES FEES	3,564
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,710

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	14,552
2006 EXPENSES PAID 2005	(498)
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,054

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10-1-2004 Ending: 9-30-2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LIFE SERVICES NETWORKS $9,142**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **YES** If YES, what is the capacity? **171**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **62,432** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **93,623**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **30,000**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **TIMOTHY J WIEWEL CPA** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.